

Health Care Costs: Say No To HB 405, Just More "Tort Reform"

"Tort Reform" Hasn't Lowered Health Care Costs In Montana

Montana has "tort reform" - the Montana Medical Association's July/August 2009 newsletter (www.mmaofficeoffice.org) touts some 45 special pieces of legislation enacted to protect health care providers - calling them "qualitatively 'better' than measures in almost all states." Those include the most restrictive cap on non-economic damages in the country, attorney fees and costs for "frivolous" lawsuits and a special "court" (the Medical Legal Panel) to screen all malpractice cases. According to the MMA's most recent statistics, medical malpractice claims in Montana have been relatively consistent over the past 10 years, with 122 claims filed in 2009, actually 25% fewer claims than in 1999, even though the number of health care providers has increased 27% in those years.

Now, with 'better' protections than almost all other states, and with the number of malpractice cases actually proportionately decreasing, you would think that Montana's health care costs would be significantly lower than states without the kind of "reforms" being asked for. Well, the you would be wrong. Montana's per capita health care cost is \$5,080 per year. Wyoming has virtually none of the Montana protections (no caps on damages, no special 'court', etc), yet their per capita health care cost is \$5,265. Where are the "significant" health care cost savings of Montana's tort reform?

One of the new myths is that so-called "defensive medicine" is a significant factor in health care costs. Supposedly doctors order unnecessary tests and medical procedures as a means to avoid lawsuits. And of course, the only cure for defensive medicine is to limit or deny the rights of persons who have been harmed by medical negligence.

But, there just aren't any facts to back up the claim that defensive medicine is a significant factor in health care costs.

The Congressional Budget Office called the evidence of defensive medicine "not conclusive," and summarized, "On the basis of existing studies and its own research, CBO believes that savings from reducing defensive medicine would be very small." Researchers at Dartmouth College echoed these conclusions, saying, "The fact that we see very little evidence of widespread physician exodus or dramatic increases in the use of defensive medicine in response to increases in state malpractice premiums places the more dire predictions of malpractice alarmists in doubt."

The Government Accountability Office (GAO) has issued similar statements questioning the occurrence of defensive medicine, saying, the overall prevalence and costs of defensive medicine have not been reliably measured, and "study results cannot be generalized to estimate the extent and cost of defensive medicine practices across the health care system." The GAO reported that even "officials from AMA [American Medical Association] and several medical, hospital, and nursing home associations told us that defensive medicine exists to some degree, but that it is difficult to measure."

To the extent that defensive medicine does exist, research has found that the motivation behind it is not liability but rather a desire to simply help a patient or, in some cases, boost physician income. One government agency found that when doctors ordered tests they almost always did so because of medical indications, and only one half of one percent of all cases involved doctors who ordered tests due solely to medical negligence concerns.

Doctors may actually practice defensively because it generates more income, according to the GAO. They identified revenue-enhancing motives as one of the real reasons behind the utilization of extra diagnostic tests and procedures.

In Florida, health authorities determined diagnostic-imaging centers and clinical labs were ordering additional tests because the majority were physician-owned and the tests provided a lucrative stream of income. Federal law now prohibits the referral of Medicare patients to certain physician-owned facilities, many of which charge double the amount in lab fees.

When the Kaiser Foundation looked at the numbers behind rising health care costs, the top factors that they came up with were 67% higher spending on prescription drugs, 59% higher spending for hospitals, 48% higher spending for physicians, 23% higher spending for better technology, and 44% higher insurance company profits. Defensive medicine didn't even make their radar screen.

If defensive medicine is actually so prevalent, you have to ask, isn't it fraud to order medical procedures that are not medically necessary? It is under Medicare:

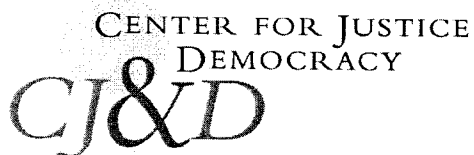
"It shall be the obligation of any health care practitioner and any other person . . . who provides health care services for which payment may be made (in whole or in part) under this Act, to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this Act . . . **will be provided economically and only when, and to the extent, medically necessary.**"

Section 42 U.S.C. § 1320c-5(a)(1).

"[N]o payment may be made under part A or part B for any expenses incurred for items or services . . . which . . . are not **reasonable and necessary for the diagnosis or treatment of illness or injury** or to improve the functioning of a malformed body member."

Section 42 U.S.C. § 1395y(a)(1)(A).

Could it be that defensive medicine is more like defensive driving - prudence and safety are the main factors, not fear of liability?



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CALLING THEIR BLUFF: FRAUD AND "DEFENSIVE MEDICINE"

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In June 2010, the *Archives of Internal Medicine* published another in a long line of anonymous doctor "surveys" conceived by organized medicine, seeking responses to questions about the very hot button political topic of "defensive medicine" and medical malpractice lawsuits.¹ Like all such surveys, its purpose was to give the impression of a scientifically conducted poll so the results could be trotted out before lawmakers to demonstrate support for the pollsters' pre-defined legislative agenda – i.e., restrictions on patients' legal rights.

While anonymous doctor surveys provide the principal foundation for the argument that widespread "defensive medicine" exists, credible organizations who have looked into the issue have had a very hard time identifying pervasive "defensive medicine," especially when managed care companies are paying the bill. For example, the Congressional Budget Office found tiny health care savings – "0.3 percent from slightly less utilization of health care services" – if severe tort reform were passed nationally. According to the CBO, if there is any problem at all, it's with Medicare, specifically its emphasis on "fee-for-service" spending, whereas private managed care "limit[s] the use of services that have marginal or no benefit to patients (some of which might otherwise be provided as 'defensive medicine')." This is consistent with what many other studies have found.²

But there is another issue. In these anonymous surveys, doctors never actually identify specific tests or procedures they have conducted for the primary purpose of avoiding a lawsuit, let alone a service they would no longer perform if severe "tort reform" were enacted. There is no better illustration of this than the June 1, 2009, the *New Yorker* magazine article called "The Cost

¹ See, Mark Crane, 'New Study Finds 91% of Physicians Practice Defensive Medicine,' *Medscape Today*, June 28, 2010; <http://www.medscape.com/viewarticle/724254>.

² When the GAO tried to find evidence of "defensive medicine," it noted, "Some officials pointed out that factors besides defensive medicine concerns also explain differing utilization rates of diagnostic and other procedures. For example, a Montana hospital association official said that revenue-enhancing motives can encourage the utilization of certain types of diagnostic tests, while officials from Minnesota and California medical associations identified managed care as a factor that can mitigate defensive practices. According to some research, managed care provides a financial incentive not to offer treatments that are unlikely to have medical benefit." *Analysis of Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, General Accounting Office, GAO-03-836, Released August 29, 2003.

Conundrum; What a Texas town can teach us about health care," by Dr. Atul Gawande. This widely-circulated article explored why the town of McAllen, Texas "was the country's most expensive place for health care." The following exchange took place with a group of doctors and Dr. Gawande:

"It's malpractice," a family physician who had practiced here for thirty-three years said. "McAllen is legal hell," the cardiologist agreed. Doctors order unnecessary tests just to protect themselves, he said. Everyone thought the lawyers here were worse than elsewhere.

That explanation puzzled me. Several years ago, Texas passed a tough malpractice law that capped pain-and-suffering awards at two hundred and fifty thousand dollars.

Didn't lawsuits go down? "Practically to zero," the cardiologist admitted. "Come on," the general surgeon finally said. "We all know these arguments are bullshit. There is overutilization here, pure and simple." Doctors, he said, were racking up charges with extra tests, services, and procedures."³

In other words, while doctors may tell pollsters that tests are done to avoid lawsuits, digging further usually reveals that there are other factors at work.⁴

Even respected pollsters and polling organizations have been criticized for bias in pushing surveys like this, and with good reason.⁵ What's more, several years ago the General

³ http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande See also, "Physicians still fear malpractice lawsuits, despite tort reforms," *Health Affairs*, September 2010, which found that doctors have a "fear of suits that seems out of proportion to the actual risk of being sued." Several explanations are suggested. One squarely blames the medical societies/lobbyists, which continuously hype the risk of lawsuits to generate a lobbying force to help them advocate for doctors' liability limits, i.e., "tort reform." A second possible explanation offered by the authors is that doctors will "exaggerate their concern about being sued, using it as a justification for high-spending behavior that is rewarded by fee-for-service payment systems. ... A third explanation relates to well-documented human tendencies to overestimate the risk of rare events and to be particularly fearful of risks that are unfamiliar, potentially catastrophic, or difficult to control. Lawsuits are rare events in a physician's career, but physicians tend to overestimate the likelihood of experiencing them. Surveys of the public demonstrate much higher levels of fear of dying in an airplane crash than in a car accident, even though the latter fate is far more likely. Severe, unpredictable, uncontrollable events are associated with a feeling of dread that triggers a statistically irrational level of risk aversion."

⁴ See, e.g., Office of Technology Assessment (OTA), U.S. Congress, Office of Technology Assessment, *Defensive Medicine and Medical Malpractice*, OTA-H-602 (1994) ("OTA found that most physicians who 'order aggressive diagnostic procedures . . . do so primarily because they believe such procedures are medically indicated, not primarily because of concerns about liability.' The effects of 'tort reform' on defensive medicine 'are likely to be small.'")

⁵ The *Connecticut Law Tribune*, which serves that state's entire legal community, once called such "tort reform" surveys a "pitiful excuse to drum up uninformed public sentiment, to create a lawyer-bashing frenzy which, when the dust settles, will simply mean that voters will find out they have lost their fundamental rights of redress." "Vox Populi Justice," *Connecticut Law Tribune*, February 5, 2001. In 1997, the New York State Bar Association, which represents both the defense and plaintiffs' bar, criticized polls conducted by John Zogby for New York's major business "tort reform" coalition, New Yorkers for Civil Justice Reform (NYCJR). Richard Behn, who headed Numbercrunchers, a national polling organization, said, "Although John Zogby is a respected pollster, the survey he prepared for New Yorkers for Civil Justice Reform is clearly designed to test voter response to a set of arguments designed to enhance the positions of New Yorkers for Civil Justice Reform. There are no counter arguments

Accountability Office condemned anonymous "defensive medicine" doctor surveys, noting everything from low response rates (10 and 15 percent) to the general failure of surveys to indicate whether physicians engaged in "defensive behaviors on a daily basis or only rarely, or whether they practice them with every patient or only with certain types of patients."⁶ The GAO also noted that those who produced and cited such surveys "could not provide additional data demonstrating the extent and costs associated with defensive medicine."

In fact, there is even more reason to be skeptical. That is because if these doctor surveys are to be believed, they would suggest that nearly every doctor in America is violating the law. And we know that is not correct.

Recent "Defensive Medicine" Surveys

In the June 2010, the *Archives of Internal Medicine*, 2416 doctors were anonymously asked to consider the following two statements and indicate if they agreed or not:

"Doctors order more tests and procedures than patients need to protect themselves against malpractice suits."

"Unnecessary use of diagnostic tests will not decrease without protections for physicians against unwarranted malpractice suits."

About 9 out of 10 doctors say they agreed. Notably, they were not asked if they personally engage in the practice (let alone the kind of detail the GAO suggested). Like all similar "push poll" surveys, there were no counter viewpoints to provide any balance to these statements, nor were there any follow up questions asking doctors to identify the specific unneeded tests they may have ordered. Had these questions been asked, the survey results would undoubtedly have been substantially different.

A doctor who bills Medicare or Medicaid for tests and procedures done for a personal purpose – e.g., lawsuit protection – as opposed to what is medically necessary for a patient, is committing fraud under federal and state Medicare/Medicaid programs.

The Medicare law states:

included in the poll to provide any balance to these statements." Moreover, he called the polls "incendiary . . . filled with loaded language . . . [an effort to] move public opinion in a particular direction advantageous to the poll sponsor." Letter from Richard J. Behn, President, Numbercrunchers, Inc., to Joshua Pruzansky, President, New York State Bar Association, June 23, 1997. In 1995, a "poll" on the subject of "tort reform," conducted by Frank Luntz, was roundly criticized for "push-poll" bias. Luntz admitted that he had "counted people as favoring 'tort reform' if they accepted the statement that 'we should stop excessive legal claims, frivolous lawsuits and overzealous lawyers.'" Diane Colasanto, former President of the American Association for Public Opinion Research, said, "You can't measure public opinion with leading questions like these." See, "The GOP Contract: Luntz Admits Initial Polling was 'Flawed,'" *The Hotline*, November 14, 1995.

⁶ *Analysis of Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, General Accounting Office, GAO-03-836, Released August 29, 2003.

"It shall be the obligation of any health care practitioner and any other person . . . who provides health care services for which payment may be made (in whole or in part) under this Act, to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this Act . . . will be provided economically and only when, and to the extent, medically necessary."⁷

"[N]o payment may be made under part A or part B for any expenses incurred for items or services . . . which . . . are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."⁸

Providers cannot be paid and/or participate in the Medicare program unless they comply with these provisions, and they impliedly certify compliance with these provisions when they file claims. Thus, if they are not in compliance, the certifications and the claims are false. Providers who do not comply and/or file false claims can be excluded from the Medicare program.⁹

Perhaps more importantly, the Medicare claim form (Form 1500) requires providers to expressly certify that "the services shown on the form were medically indicated and necessary for the health of the patient."¹⁰ If the services are, to the doctor's knowledge, medically unnecessary, the claim is false.

State Medicaid Law

State law tends to track the federal requirements, including New York's law. For example, according to the New York State Office of Medicaid Inspector General:

"Some Medicaid providers engage in fraudulent activities. The Office of the Medicaid Inspector General reviews provider billing and other activities and investigates charges of fraudulent behavior in order to take all appropriate actions."¹¹

"Some examples of provider fraud include: . . . Taking unnecessary x-rays, blood work, etc."¹²

New York's regulations specify that failure to comply with federal law is also considered an "Unacceptable practice[]" under the medical assistance program."¹³ Further, "an unacceptable practice is conduct which constitutes fraud or abuse and includes:

⁷ 42 U.S.C. § 1320c-5(a)(1).

⁸ 42 U.S.C. § 1395y(a)(1)(A).

⁹ See also, *Mikes v. Strauss*, 274 F. 3d 687, 700-1 (2d Cir. 2001) and cases cited therein (holding that compliance with § 1320c-5(a)(1) is a condition of participation in the Medicare program but not a condition of payment; other courts do not make that distinction, e.g., *United States ex rel. Kneepkins v. Gambro Healthcare, Inc.*, 115 F. Supp. 2d 35, 41 (D. Mass. 2000) (holding that compliance with § 1320c-5(a)(1) is a condition of payment).

¹⁰ See., <http://www.cms.gov/cmsforms/downloads/CMS1500805.pdf>.

¹¹ See., <http://www.omig.ny.gov/data/content/blogsection/8/52/>

¹² See., <http://www.omig.ny.gov/data/content/view/28/52/>

¹³ NYCRR §515.2

- (1) False claims. (i) Submitting, or causing to be submitted, a claim or claims for ... medical care, services or supplies provided at a frequency or in an amount not medically necessary."¹⁴

Moreover, like federal law, physicians must file a Claim Certification Statement, certifying:

I understand that payment and satisfaction of this claim will be from federal, state and local public funds and that I may be prosecuted under applicable federal and state laws for any false claims, statements or documents or concealment of a material fact.¹⁵

And if they do submit a false claim, the sanctions are significant and include removal from the program.¹⁶

Conclusion

We do not believe that most physicians in the country are submitting false claims to Medicare and Medicaid. We believe most physicians are good doctors who order tests and procedures for the very reasons that they certify to Medicare and Medicaid – because they are medically indicated and necessary for the health of the patient. Perhaps some doctors do commit fraud, and clearly “fee-for-service” medicine creates a perverse incentive for providers to do too many tests. But it certainly is the lesson of history that even if you remove litigation as a factor, the extent of tests and procedures that will be ordered will not change. Enacting so-called “tort reform” will continue to fail as a solution to this country’s health care problems.

(Thanks much to Lesley Ann Skillen for her assistance with this paper.)

¹⁴ *Ibid.*

¹⁵ Information for All Providers, “General Billing,” found at <http://www.emedny.org/ProviderManuals/AllProviders/index.html>

¹⁶ See, <http://www.omig.ny.gov/data/content/view/71/52/>